MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00757

Reg. Dist. No. 2 89

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 M 26 D
Hospital, institution, or street address where death occurred: Laurel Sanitarium
How long in hospital or institution? 10 M 26 D

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: District Columbia County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3414 - 10th Place S.E (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Stanley Addicks

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Isla Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5 - 1869

8. AGE: Years	Months	Days	If less than one day
77	5	5	hrs. min.

9. Birthplace: Philadelphia Penn. (Town, county, and state)
10. Usual occupation: Musician
11. Industry or business

FATHER
12. Name: Charles Addicks
13. Birthplace: Penn.

MOTHER
14. Maiden name: Mary Weaver
15. Birthplace: Penn.

16. Informant: Sanitarium Records
Address: Laurel Sanitarium, Laurel, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 11 - 1947 (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: The S. H. Hines Co
Address: 2901 14th St. N.W.

19. Jan 11 1947 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1946 to Jan. 10 1947 and that I last saw h[illegible] alive on January 10 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1/2/47
Due to: General Arterio Sclerosis	Unk
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Wetherell M. D. or other
Address: Laurel S[illegible] Laurel, Md. Date signed 1/10/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00758

46d

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County: Prince George County
City or town: Michigan Park Hills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
5408 15th Ave. Michigan Park Hills
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4511 Harling Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: CHARLOTTE ANN ALDEN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Everett A. Alden
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	13	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Clerk- American Red Cross
11. Industry or business

FATHER
12. Name: William H. Bosley
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Susan A. Burkhart
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Everett A. Alden
Address: 4511 Harling Lane, Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/23/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland

18. Funeral director: W. Reuben Pumphrey
Address: Bethesda, Maryland

19. Jan 22 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1947, at 2.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1946 to Jan. 20 1947 and that I last saw h.e.r. alive on 19 Jan. 1947

	DURATION
Immediate cause of death: Generalized Metastatic adenocarcinoma	2½ months
Due to: Adenocarcinoma of rectum - grade + 2	2½ years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Adenocarcinoma of rectum
Combined Abdomino-perineal resection of rectum
Date of op. June 29, 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald H. Leiper Jr. M.D.
M. D. or other
Address: 1801 Eye St. N.W., Wash. D.C. Date signed: Jan. 20, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157-2

★13 007593

Reg. Dist. No. 2342

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince Georges
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Arthur Allen Alexander

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ~~Melvin Alexander~~ Bertha P. Alexander
6.(c) If alive, give age: 41 of 34 years

7. Birth date of deceased (mo., day, yr.): Jan. 10th 1947

8. AGE:

Years	Months	Days	If less than one day
		20	7 hrs. — min.

9. Birthplace: Oxon Hill, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Melvin Alexander
13. Birthplace: Lunsby, Va.

MOTHER
14. Maiden name: Bertha Price
15. Birthplace: Oxon Hill Md.

16. Informant: Bertha Price Alexander
Address: 4922 Livingston Rd S.E. D.C.20

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 31-1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Rd. Suitland Md.

18. Funeral director: Thomas E. Murray
Address: 2007 Nichols Ave. S.E. D.C.

19. Jan 30 1947 (Date rec'd by registrar) Harold J. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 10th 1947 to Jan 20th 1947 and that I last saw him alive on January 29 1947

	DURATION
Immediate cause of death: Mal nutrition	20 days
Due to: Contractual muscular inertia, due to malformation. There was no complete occlusion of C.V.S.R.	20 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arthur M. Meloy M. D. or other
Address: 4400 Benning Rd. D.C. Date signed: 1-30-47

1-25

2-2240-1-20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(107)

CERTIFICATE OF DEATH

00760

Reg. Dist. No. 2391

1. PLACE OF DEATH:

County: Prince Georges

City or town: Rural Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos.

Hospital, institution, or street address where death occurred: Washington Blvd - Harris Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: North Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: RICHARD ALLEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Baby

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JUNE 17 1946

8. AGE:

Years	Months	Days	If less than one day
—	6	19	..... hrs. ..... min.

9. Birthplace: Washington D.C.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Carol Chester Allen

13. Birthplace: Piedmont, Mo.

MOTHER 14. Maiden name: Mildred Weisa

15. Birthplace: Brooklyn, N.Y.

16. Informant: Carl Chester Allen

Address: North Beach, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Washington, D.C.

18. Funeral director: Lloyd Kaiser Inc.

Address: 381 Main St. Laurel Md.

19 1-7 (Date rec'd by registrar) 19 47 Cas E Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 6 19 47 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/3 19 46, to 1/6 19 47 and that I last saw h.. alive on 12/24 19 46

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Influenza	2-3 days
Due to:	
Other conditions: Congenital absence of eye balls, general malnutrition (Include pregnancy within 3 months of death)	6 mo

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A Stephens MD M. D. or other

Address: Laurel Md. Date signed 1/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

2-25

2-2390-2-10

STATE OF MARYLAND—CERTIFICATE OF DEATH

00761

932

V. S. No. 1

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Prince Georges — Registration Dist. No. 2450

Village or City Greenbelt — No. 7E Crescent Rd. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Julia W. Bach — If U. S. Veteran, specify WAR —

(a) Residence: No. 7E Crescent Rd. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	WIDOW.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of THEODORE F. BACH

6. DATE OF BIRTH (month, day, and year) NOVEMBER 10, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	19	

OCCUPATION

8. Trede, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. HOUSEWIFE

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked et this occupation (month and year)

11. Totel time (years) spent in this occupation LIFE.

12. BIRTHPLACE (city or town) LEONARDTOWNE (State or country) MARYLAND

FATHER

13. NAME MICHAEL WILKINSON

14. BIRTHPLACE (city or town) MARYLAND (State or country)

MOTHER

15. MAIDEN NAME JULIA STONE

16. BIRTHPLACE (city or town) MARYLAND (State or country)

17. INFORMANT HELEN M. ZOELLNER (Address) #7E CRESCENT ROAD, GREENBELT

18. BURIAL, CREMATION, OR REMOVAL Place MT. Olivet Cemetery D.C. Date Jnbruary 1, 1947

19. UNDERTAKER James F. Ryan, Inc. (Address) 317 Penna. Ave., S.E.

20. FILED Jan 30, 1947 James Berry Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 29 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1947, to Jan 28, 1947.

I last saw her alive on Jan 28, 1947; death is said to have occurred on the date stated above, at 9:30 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Respiratory failure	
Coronary Sclerosis	

Other Contributory Causes of Importance:

Chronic Myocardosis due to Coronary Insuff.	

Neme of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If deeth was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of Injury

24. Wes disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) William M. Eisaur M. D.

(Address) 20 B. Ridge Rd; Greenbelt, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06762

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 3 mos., 26 days.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 3 mos., 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 222 Mississippi Ave., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JESSAMINE C. BEW

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Peter H. Bew

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1907

8. AGE:	Years	Months	Days	If less than one day
	39	11	17	hrs. min.

9. Birthplace: Youngsville, North Carolina
(Town, county, and state)

10. Usual occupation: Nurse, R. N.

11. Industry or business:

FATHER
12. Name: Frederick A. Cheatham
13. Birthplace: Oxford, North Carolina

MOTHER
14. Maiden name: Maud Freeman
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-24-47 (month) (day) (year)
Cemetery or crematory: to Washington DC
Location:

18. Funeral director: W. W. Chambers Co.
Address: 517-11th St. S.E.

19. Jan. 24, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24, 1947 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27, 1945 to Jan. 24, 1947 and that I last saw h... alive on Jan. 24, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr. 7 mo.
Due to: Tuberculous Laryngitis	11 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 1/24/47

2-25

2-2430- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00763

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 423 - 4th St., N. E.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: PHYLISS IRENE BLEVINS

3.(b) Social Security Number: 577-20-6695

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Harold Blevins

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): July 23, 1921

8. AGE: Years	Months	Days	If less than one day
25	5	7	..... hrs. ..... min.

9. Birthplace: Buffalo, New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Fred Meininger
13. Birthplace: Buffalo, New York

MOTHER
14. Maiden name: Ruby Peters
15. Birthplace: Wharton, Pennsylvania

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: W. W. Chambers Co. (Rm)

Address: 517 - 11th St. S.E., Wash. D.C.

19. Jan 16 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1947, at 5-32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1946 to Jan 16 1947 and that I last saw her alive on Jan 16 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mo 6 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430-2710

End of Month

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926

00765 3145T

Reg. Dist. No.

1. PLACE OF DEATH:
County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6710 – 44 ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Beverly Mae Bookstaver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 28, 1926

8. AGE: Years	Months	Days	If less than one day
20			..... hrs. ..... min.

9. Birthplace Enfield NC (Town, county, and state)
10. Usual occupation Cashier
11. Industry or business Randall, Haynes
FATHER 12. Name Homer F Bookstaver
13. Birthplace Brooklyn Pa
MOTHER 14. Maiden name Eva M Edwards
15. Birthplace Centerville Ky
16. Interment Homer F Bookstaver
Address 6710 – 44 ave
17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 30 1947 (month) (day) (year)
Cemetery or crematory
Location Washington DC
18. Funeral director Shillum Co
Address 2901 – 14 St N W DC
19. Jan 30 1947 (Date rec'd by registrar) Mrs. Jos. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1947 at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1947 to Jan. 30 1947 and that I last saw h.e.r alive on Jan. 29, 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	1 mo.
Due to Rheumatic heart disease with aortic insufficiency	6 mo.
Due to and Mitral stenosis.	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank S Bacon M.D.
M. D. or other
Address 62 Knowles Ave Kensington, Md. Date signed Jan 30 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-25

62-2450-1-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

00764

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State Maryland County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 320 - Montgomery

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry Edward Bean

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 16 1873

8. AGE:

Years	Months	Days	If less than one day
73	0	25	..... hrs. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Plumber

11. Industry or business Contracting Work

FATHER 12. Name Wm Noble Bean

FATHER 13. Birthplace Md

MOTHER 14. Maiden name Henrietta Jane

MOTHER 15. Birthplace Thomasville, Ga.

16. Informant Mrs W. Lawrence Bowie

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 14 1947 (month) (day) (year)

Cemetery or crematory Glenwood

Location Baltimore Rd Washington D.C.

18. Funeral director W. H. Wells Undertaking

Address Laurel Md

19. Jan 13 1947 M. Beauchamp

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11 19 47, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 46, to Jan 11 1947

and that I last saw h[illegible] alive on Jan 9 1947

Immediate cause of death	DURATION
Carcinoma Pancreas	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M Warren M D

M. D. or other

Address Laurel Date signed 1/13/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00766

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Hyattsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? seven years

Hospital, institution, or street address where death occurred: Sacred Heart Home, Hyattsville, Md.

How long in hospital or institution? seven years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 5801 Queens Chapel Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Mary Bryan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1, 1878

8. AGE: Years	Months	Days	If less than one day
68	10	14	..... hrs. ..... min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual occupation housekeeper

11. Industry or business

FATHER 12. Name Mathew Bryan

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden name Martha Beall

MOTHER 15. Birthplace Washington, D. C.

16. Informant Sacred Heart Home

Address 5801 Queens Chapel Road, Hyattsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17, 1947 (month) (day) (year)

Cemetery or crematory Mt Olivet Cemetery

Location Washington, D.C.

18. Funeral director Francis J. Collins

Address 3821-14th St. N. W. Washington

19. Jan 15 1947 (Date rec'd by registrar) Mrs. Jas. Devereux (Deputy Seal) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1947, to June 13 1947

and that I last saw h... alive on June 13 1947

	DURATION
Immediate cause of death Coronary Thrombosis	3 hours
Due to Arteriosclerosis	
Due to Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE ..... M. D. or other

Address ..... Date signed June 15 1947

1-25

2-2450-1-10

Evidence for the change of year of birth is shown on G 108 2/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00767

Reg. Diat. No. 2300

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Greenbelt Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo Co.
City or town: Greenbelt Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 76 C Cresent Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME George Washington Bryant

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Bryant
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): June 6 1894 ~~1898~~

8. AGE: Years: 52 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Postmaster
11. Industry or business: Greenbelt Post Office
FATHER 12. Name: Geo. W. Bryant
13. Birthplace: Md
MOTHER 14. Maiden name: Eleanor E. Baker
15. Birthplace: Md
16. Informant: Ruth Bryant
Address: Greenbelt Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2, 1947 (month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Bladensburg Maryland
18. Funeral director: F. Gaskins Sons
Address: Hyattsville Md
19. February 1st 1947 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 JANUARY 1947 at 11 55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1946 to 30 JAN 1947 and that I last saw him alive on 30 JANUARY 1947

Immediate cause of death	DURATION
Congestive Heart Failure with Auricular Fibrillation	3 Mo
Due to: Hypertensive Cardio-Vascular disease	15 yr +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

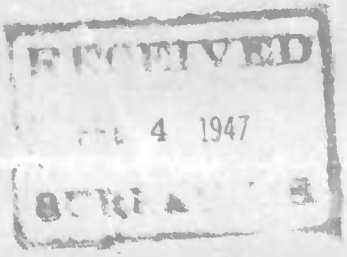
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. L. Etienne M.D.
Address: Berwyn, Md M. D. or other
Date signed: 1-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



1-35

Evidence for change of age is shown on Film D109-3121147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a ★ 00768

CERTIFICATE OF DEATH

Reg. Dist. No. 2457

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville 8
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7031 Baltimore Blvd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEORGE
City or town: HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7031 BALTIMORE BLVD.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR. HYMAN BURKO

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married ~~widowed~~

6.(b) Name of husband or wife: ada Lantzmann
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept 3 1882

8. AGE: Years: 64 to 5 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation:
11. Industry or business: Restaurant

FATHER
12. Name: Abraham Burko
13. Birthplace: Russia

MOTHER
14. Maiden name: Ada (Landsmann)
15. Birthplace: Russia

16. Informant: Son (Joseph)
Address: 7031 Baltimore Ave.

17. (Burial, cremation, or removal. Which?) Date thereof: Jan 25 1947 (month) (day) (year)
Cemetery or crematory: 3501 - 14th St N.W.
Location: Washington D.C.

18. Funeral director: Bernard Danzansky & Son
Address: 3501-14th St. N.W.

19. Jan. 25 1947 (Date rec'd by registrar) Mrs. Jos. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-24-47 19.... at 11:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1945, to Jan. 24 1947 and that I last saw h... alive on Jan 24 1947

Immediate cause of death	DURATION
(a) Malignant Hypertension	
Due to:	
Due to:	
Other conditions: Cardio-Vascular Renal Disease.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. Hertz M.D.
M. D. or other
Address: Hyattsville, Md. Date signed: 1-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1 - 25

2 - 2450 — 1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95 F

00769

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address, where death occurred:
523 - Addison Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 523 Addison Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Robert Cady

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1906

8. AGE: Years 40 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Ventried J. Columbia (Town, county, and state)

10. Usual occupation Stereotyper

11. Industry or business News Paper

FATHER 12. Name William A. Cady

13. Birthplace Washington DC

MOTHER 14. Maiden name Martha M. Mundell

15. Birthplace Annapolis. MD.

18. Informant Mrs. Martha M. Cady

Address 523 - Addison Road, Seat Pleasant

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30 47 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington DC

18. Funeral director Deal Funeral Home

Address 4812 Ga. Ave NW

19. Jan. 28 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1947, at 2:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congestive heart failure	
Due to Rheumatic heart disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Forestville md Date signed 1-28-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00770

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 26 days.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 M. Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FELMON. CHISHOLM

3.(b) Social Security Number: 577-22-0873

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Separated

6.(b) Name of husband or wife: Elsie Jones Chisholm
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): January 25, 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
26	11	12		

9. Birthplace: Charleston, South Carolina
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Sheraton Hotel

FATHER
12. Name: Richard Chisholm
13. Birthplace: Charleston, South Carolina.

MOTHER
14. Maiden name: Sadie Brent
15. Birthplace: Charleston, South Carolina

16. Informant: Deceased
Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D. C.
18. Funeral director: R.N. Horton
Address: 1322 U-St NW Wash. D.C.
19. Jan. 7, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7th 1947, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1946, to January 7th 1947 and that I last saw h.. alive on January 7th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mos.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 1/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c 00771

CERTIFICATE OF DEATH

Reg. Dist. No. 2451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince George
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4705 41 Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ELTON JAMES CHURCH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife Minnie Church
7. Birth date of deceased (mo., day, yr.) May 11, 1883 6.(c) If alive, give age 43 years
May 11, 1883

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace Va. (Town, county, and state)
10. Usual occupation Janitor
11. Industry or business
FATHER 12. Name James Church
13. Birthplace Va.
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Minnie Church
Address 4705 41 Pl. Hyattsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1947 (month) (day) (year)
Cemetery or crematory Harmony Cemetery
Location Washington D.C.
18. Funeral director Henry S. Washington & Sons
Address 467 N St. N.E. Wash. D.C.
19. Jan 23" 1947 (Date rec'd by registrar) Mrs. Jas. Deverell Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1947, at 11 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945, to Jan 20 1947 and that I last saw h. alive on Jan 17 1947

Immediate cause of death	DURATION
Respiratory failure	1 hr
Due to Carcinoma of bronchus	15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. S. Hudson M.D.
M. D. or other
Address Laurel Md Date signed Jan 21, 1947

1-25

2-2450-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

00772

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME T. Van Clagett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
75			hrs. min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)
10. Usual occupation: Attorney
11. Industry or business

MOTHER FATHER
12. Name: Gonsalva Clagett
13. Birthplace: Upper Marlboro, Pr. Geo. Co. Md.
14. Maiden name: Caroline Van Antwerp
15. Birthplace: Keokuk, Iowa.

16. Informant: T. Van Clagett, Jr.
Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 24 47 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Upper Marlboro Md
18. Funeral director: Butcher Bros
Address: Upper Marlboro Md
19. 1/18 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1947, at 8:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 December 1946, to 18 December 1947 and that I last saw h[illegible] alive on 17 December 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	3 weeks
Due to: Arterio-sclerotic cardio-vascular disease	2yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert B. Lanier M. D. or other
Address: Upper Marlboro Md Date signed: 1-18-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00773

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos., 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2455 P. St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LENA C. CLARK

3.(b) Social Security Number: 579-12-9090

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Donald Clark
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): December 10, 1915

8. AGE: Years	Months	Days	If less than one day
31	0	29	hrs. min.

9. Birthplace: Montgomery Co., Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Samuel Jackson
13. Birthplace: Loudon, Virginia

MOTHER
14. Maiden name: Bessie White
15. Birthplace: Hernon, Virginia

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 9, 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: W. Ernest Garrison
Address: 1432 you st nw.

19. Jan. 9 1947 Rowland S. Phibbs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1947, at 8:05 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 3 1946 to Jan. 9 1947 and that I last saw h.e.r. alive on Jan. 9 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 1-9-47

2-25

2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 ★ 00774

Reg. Dist. No. 2422

1. PLACE OF DEATH:
County: Prince George
City or town: Glenarden Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Glenarden Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: # 1 Front st.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William B. Clark

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	Married

6 (b) Name of husband or wife: Mrs Rosa P. Clark
6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Dec 25th 1878

8. AGE: Years: 68 Months: Days: 29 If less than one day: hrs. min.

9. Birthplace: Nathalie, Campbell Co Va. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Builder
FATHER 12. Name: Pleasant Clark
13. Birthplace: Va.
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Mrs Rosa P. Clark.
Address: R.F.D. # 2. Landover Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 27-1947 (month) (day) (year)
Cemetery or crematory: Glenarden Church
Location: Glenarden Md
18. Funeral director: Thomas Frazier Co.
Address: 389 R. I. Ave N. W.
19. Jan 24 1947 (Date rec'd by registrar) Mrs Jack Bennette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to January 23 1947, and that I last saw him alive on January 23 1947.

	DURATION
Immediate cause of death: Uremia	5 days
Due to: Carcinoma of Prostate	Undetermined (diagnosed January 1946)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: 200 N.Y. Ave. N.W. Wash. D.C. Date signed: Jan. 24, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2420 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 06775

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 E. St., S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: GLADYS COLBERT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Raymond Colbert
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1902

8. AGE: Years	Months	Days	If less than one day
44	11	15	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frank —
13. Birthplace: Washington, D. C.
MOTHER 14. Maiden name: Marie Pryor
15. Birthplace: King George, Virginia
16. Informant: Deceased
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 9 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: R. L. Campbell
Address: 423 4½ St. S.W.
19. Jan. 9 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1947, at 9:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3 1947, to Jan. 9 1947
and that I last saw her alive on Jan. 9 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale Md. Date signed: 1-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2 — 2432 — 2 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a ★ 00776242

CERTIFICATE OF DEATH

Reg. Dist. No. 2-42

1. PLACE OF DEATH:

County: Prince Georges

City or town: Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

201-50th Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 201-50th Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sabra Florine Dolan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: James Thomas Dolan

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept 16, 1888

8. AGE: Years: 58 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Missouri (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Sam Hilton

FATHER — 13. Birthplace: Arkansas

MOTHER — 14. Maiden name: Matilda Hudson

MOTHER — 15. Birthplace: Joplin, Missouri

16. Informant: Williams Edwin Dolan

Address: 1223 N St NW Washington DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-25-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Road.

18. Funeral director: W. W. Chambers Co.

Address: 517-11th st. S.E.

19. Jan. 22 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1947, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner M.D. or other

Address: Forestville Md Date signed: 1-22-47

VS A15 19-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92b

06777

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt. Rainier (If outside city or town limits, write RURAL and give nearest town)
Street No. 3201 Perry St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Robert Durham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Marguerite Gamache
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 27-1902

8. AGE: Years	Months	Days	If less than one day
44	1	8	hrs. min.

9. Birthplace: Tennessee (Town, county, and state)
10. Usual occupation: Heating contractor
11. Industry or business
FATHER 12. Name: Thomas L. Durham
13. Birthplace: Mississippi
MOTHER 14. Maiden name: Alice Wald
15. Birthplace: Mississippi
16. Informant: Sanitarium Records
Address: Laurel Gen., Laurel, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/1947 (month) (day) (year)
Cemetery or crematory: F.L. Lincoln
Location: Wash. Balto. Blvd. + D.C. Line, Md.
18. Funeral director: Wm. J. Nalley
Address: 3200-R.I. Ave. Mt. Rainier, Md.
19. Jan 3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1947, at 8:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21 1946, to Jan. 1 1947
and that I last saw [illegible] alive on Jan. 1 1947

	DURATION
Immediate cause of death: Cardiac decompensation due to	12/21/46
Due to: Mitral Regurgetation due to	Unk.
Due to:	
Other conditions: Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Wetherell, M.D. (M. D. or other)
Address: Laurel, Maryland Date signed: 1/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00778

93d

Reg. Diat. No. 2420

1. PLACE OF DEATH:
County: Prince George
City or town: Silver Hill md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Silver Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4786 Branch Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: MOLLIE ROBERT ELDER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed.

6.(b) Name of husband or wife: William C. Elder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12 1875

8. AGE: Years	Months	Days	If less than one day
71			..... hrs. ..... min.

9. Birthplace: Charlotte Co. Va
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Ruben R. Garrison
13. Birthplace: Va

MOTHER
14. Maiden name: Mary L. Crook
15. Birthplace: Va

16. Informant: Mrs Estelle S. Watson
Address: 4786 Branch ave. S. E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-24-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland md
18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S. E.

19. Jan. 22 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 22 1947, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 8 1947, to JAN 22 1947
and that I last saw her alive on JAN. 19 1947

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to Congestive Heart Failure	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Tubaderas M.D. (M. D. or other)
Address: 311 F-Ala. Ave. S.E. Wash D.C. Date signed 1-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1195 00779

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georgie Co.
City or town: Ardmore Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington D.C. County:
City or town: 4007 Conn ave. N.W
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Elliot

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
Male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 17. 1946

8. AGE: Years: | Months: 1 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: None;-

11. Industry or business

FATHER
12. Name: Lt Col owen Elliot
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Elizabeth M. Conway
15. Birthplace: Missouri

16. Informant: Lt Col owen Elliot
Address: 4007 Conn ave N.W Washington D.C.

17. Burial (Burial, cremation, or ~~removal~~. Which?) Date thereof: Jan 9, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Va.

18. Funeral director: L Gracia sons
Address: Hyattsville Md.-

19. 1/9 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1947, at 9 35 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 29 1946, to Jan 7 1947
and that I last saw h.l.i.m. alive on Jan 2 1947

Immediate cause of death	DURATION
Intestinal Invagination	
Mongoloid	1 Mo
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney M.D.
M. D. or other
Address: Cheverly-Hyattsville, Md. Date signed: 1-8-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108 06780

CERTIFICATE OF DEATH

Reg. Diat. No. 2390

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
307 Prince George ST.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pro Geo Co
City or town Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9032 Baltimore Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME alta Belle Fairbanks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Edward L. Fairbanks
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 18. 1864

8. AGE: Years 82 | Months 11 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Marshall Thomas Wright
13. Birthplace Ohio

MOTHER
14. Maiden name Tilitha Robinson
15. Birthplace Ohio

16. Informant Mrs Jean Brown
Address Berwyn Md
17. Transportation
(Burial, cremation, or removal. Which?) Date thereof Jan 10/1947 (month) (day) (year)
Cemetery or crematory Milford Center Cemetery
Location Milford Center Ohio
18. Funeral director F. Eschs son
Address Hyattsville Md
19. 1/9 1947 (Date rec'd by registrar) Amanda Downey Registrar M. Bradhead

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9th 1947, at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/7 1947, to 1/9 1947 and that I last saw h[illegible] alive on 1/9 1947

Immediate cause of death	DURATION
Lobar Pneumonia	3 d
Due to Acute Cardiac Dilatation	1 d.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE B Adams M. D. or other
Address Hyattsville Md Date signed 1/9 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

Evidence for the change of age is shown on G 108 1/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06781

94a

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Geo
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Prince Geo General Hospital
How long in hospital or institution? ½ Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5502 Bolt Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wm. Forcum.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Forcum
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec 6, 1892

8. AGE: Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Ridgewood, New Jersey (Town, county, and state)
10. Usual occupation: Contractor
11. Industry or business: Beef Emp. Loyd

FATHER
12. Name: Forcum, William
13. Birthplace: Md.

MOTHER
14. Maiden name: Silver, Elizabeth
15. Birthplace: Md

16. Informant: Mr. Wm Dunn
Address: 4301 Tuckerman St. Un. Park
17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan 15, 1947 (month) (day) (year)
Cemetery or crematory: Beaver Dam Churchyard
Location: Shenandoah Co, Virginia
18. Funeral director: F. Gaeths sons
Address: Hyattsville Md.
19. 1/16 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1947 at 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13, 1947

Immediate cause of death	DURATION
Cardiac Failure	13 days
Due to: Coronary Thrombosis 1st attack Jan 1/47	
Due to: 2nd attack " 13/47	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph S. Garden M.D.
M. D. or other
Address: Hyattsville Md. Date signed 1/13/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06782

45d

CERTIFICATE OF DEATH

Reg. Dist. No. 2451

1. PLACE OF DEATH

County: Prince George

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred: Leland Memorial Hosp.

How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 267 Hannover St. (If rural, give LOCATION)

2.(a) If veteran, name war: /

3. (a) FULL NAME: Albert Finley France

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Hill France

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years: 78 | Months: 8 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired from

11. Industry or business: Photographic business

FATHER — 12. Name: William Cobb France

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Isabelle Finley

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address: (Son) Mr. Albert Finley France Jan. 3400 Connecticut ave., D.C.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-16-47 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Washington, Colmar Manor, Md.

18. Funeral director: W. H. Chambers Co.

Address: 5801 Cleveland ave. Riverdale, Md

19. Jan. 16 1947 (Date rec'd by registrar) Mrs. Jos. Devers Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14 1947, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10, 1947, to January 14 1947 and that I last saw him alive on January 14, 1947

	DURATION
Immediate cause of death: Pulmonary Edema	1 day
Due to: H.T. Failure	1 wk
Due to: Carcinoma of Right Mandible w Metastases Regional Lymph nodes & prostate	1 yr.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Aberglus healed ulcer of stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter W. Gibson, M.D. M. D. or other

Address: Riverdale, Md. Date signed: Jan. 15, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-2450- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932d ★ 00783

Reg. Dist. No. 245T

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Leland Memorial Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Prince Georges

City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6910 Dartmouth Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr Lynn Joseph Frazier

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of ~~husband~~ or wife: Mrs Catharine Frazier

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 21 1874

8. AGE:

Years	Months	Days	If less than one day
72		11	...hrs. ...min.

9. Birthplace: Minnesota
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired Farmer

FATHER
12. Name: Thomas Frazier
13. Birthplace: Maine

MOTHER
14. Maiden name: Lois Hoar
15. Birthplace: Maine

16. Informant: Hospital chart
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1947 (month) (day) (year)

Cemetery or crematory

Location: Hoople North Dakota

18. Funeral director: J. T. Chambers Co

Address: 5801 Cleveland Ave., Riverdale, Md.

19. Jan 12 1947 (Date rec'd by registrar) Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1947, at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1946, to Jan 11 1947 and that I last saw him alive on Jan 11 1947

	DURATION
Immediate cause of death: Congestive Heart Failure	6 weeks
Due to: Coronary Thrombosis	6 weeks
Due to: General Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Old and recent infarcts in heart.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

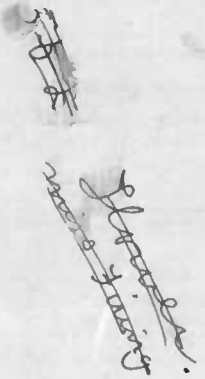
23. SIGNATURE: L W Malin MD
M. D. or other

Address: Riverdale Md Date signed: 1-13-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25

2-2450 - 1-10

00784

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince George's

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

Lanham-Severn Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lanham-Severn Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Carl Francis Gantt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22, 1946

8. AGE: Years | Months: 5 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Robert Gantt

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Florence Agnes Hamilton

MOTHER — 15. Birthplace: Maryland

16. Informant: Florence Agnes Gantt

Address: Glendale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9, 1946 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Lanham Md

18. Funeral director: F. Gaddis sons

Address: Hyattsville Md.

19. 1/9 (Date rec'd by registrar) 19 47 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 19 47, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Tuberculosis	
Due to: Pneumonia, Broncho.	
Duration: Indefinite. C.W.&R.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Forestville Md. Date signed: 1-8-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

06785

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: Tantum - Seven Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Tantum Seven Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Carolyn Tonnie Gantt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 22, 1946

8. AGE: Years: — Months: 5 Days: 16 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Robert Gantt

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Florence Ann Hamilton

MOTHER — 15. Birthplace: Maryland

16. Informant: Florence Ann Gantt

Address: Glendale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9. 1946 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Lanham Md.

18. Funeral director: F Gasch's sons

Address: Hyattsville Md.

19. 1/9 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1947, at 4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Toxemia	
Due to: Pneumonia, bronchopneumonia, Cerebral	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Deceased was not autopsied.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Upper Marlboro Md Date signed 1-8-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

Evidence for the change of age is shown on G 108 2/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0078

83a

Reg. Dist. No. 245 1

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 hrs

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 21 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4990 Rhode Island ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Gibson, Mrs Dorothy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Clyde R. Gibson

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): April 27. 1895

8. AGE: Years	Months	Days	If less than one day
51	8	25	..... hrs. ..... min.

9. Birthplace: Rockingham Co. Va.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: Henry Ryan
13. Birthplace: Rockingham Co. Va.

MOTHER
14. Maiden name: Lucy Leap
15. Birthplace: Rockingham Co. Va.

16. Informant: Vernon H. Gibson. son
Address: 453 Melon St. S.E. Washington D.C.

17. Burial, cremation, or removal. Burial. Date thereof: Jan 26 1947 (month) (day) (year)

Cemetery or crematory: McGlyeesville

Location: near Harrisonburg Va.

16. Funeral director: L Gaaches Sons

Address: Hyattsville md

19. Jan 26 1947 (Date rec'd by registrar) Mrs Jas Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1947, to Jan 25 1947 and that I last saw h[illegible] alive on Jan 25 1947

	DURATION
Immediate cause of death: Apoplexy	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. Emshan M. D. or other

Address: 4408 Queensbury Rd. Riverdale Date signed: 1-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

birthdate

Evidance for the change of age is shown on G 108 2/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 00787

Reg. Dist. No. 2420

1. PLACE OF DEATH:
County: PR. GEO.
City or town: CHAPEL OAKS
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 1126 - CHAPEL OAKS DRIVE.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PR. GEO.
City or town: CHAPEL OAKS Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1126 - CHAPEL OAKS DRIVE
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: JOSEPH GIBSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COL	

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 29, 1877 1876

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: ALABAMA
(Town, county, and state)
10. Usual occupation: LABORER
11. Industry or business
FATHER 12. Name: BOB GIBSON
13. Birthplace: ALA.
MOTHER 14. Maiden name: SARAH QUEEN
15. Birthplace: ALA
16. Informant: BLANCHE GIBSON
Address: 1126 - CHAPEL OAKS DR.
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof JAN. 26, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: John A. Gerard
Address: 30 N. C St. N.E.
19. Jan 26 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1947, at 1 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Jan. 1947, and that I last saw him alive on 1/26/47 19

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Coronary Sclerosis	6 mo's
Due to Arteriosclerosis	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James Gregory M.D. (M.D. or other)
Address: 1719 - 2nd St. N.W. Washington, D.C. Date signed 1/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

00788

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54C)

CERTIFICATE OF DEATH

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County: Prince Geo. Co
City or town: Takoma Park md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Prince Geo Co
City or town: Takoma Pk. md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Allegheny ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Douglas C. Giles

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29-1942

8. AGE: Years: 4 Months: 2 Days: 15 If less than one day: hrs. min.

9. Birthplace: Methuen, Mass (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER
12. Name: Clarence A. Giles
13. Birthplace: Mass

MOTHER
14. Maiden name: Mary Forbes
15. Birthplace: Ga

16. Informant: Clarence A Giles
Address: 107 Allegheny ave. Takoma Pk md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17-47 (month) (day) (year)
Cemetery or crematory: Arlington Natl Cemetery
Location: Arlington Va

18. Funeral director: W W Chambers Co
Address: Riverdale - md

19. Jan 15 1947 (Date rec'd by registrar) James Sevey (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1947 at 1155 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1 May 1946 to 14 Jan 1947
and that I last saw him alive on 21 December 1946

Immediate cause of death	DURATION
Neuroblastoma with metastasis to bone & mediastinal node	
Due to	
Due to	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work?

23. SIGNATURE: MM Greenfield Capt USA M. D. or other
Address: Walter Reed Gen Hosp Washington 12 DC Date signed: 1/15/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00789

170C

CERTIFICATE OF DEATH

Reg. Diat. No. 2320

1. PLACE OF DEATH:
County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, institution, or street address where death occurred:
Crane Highways and Central Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clements Ginter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Pullman, Ill
(Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

FATHER
12. Name Steven Ginter
13. Birthplace Indiana

MOTHER
14. Maiden name Agnes Jackowski
15. Birthplace Poland

16. Informant R. M. Dunbek
Address Mitchellville, Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 1-8-47. (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Bladensburg, Md

18. Funeral director Pitchie Bros
Address Upper Marlboro, Md

19. Jan 7 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 19 47 at 1308 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Pneumonia and shock	
Due to Fracture skull	
Due to Compound fracture left arm	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 1-5-47
Where did injury occur? Hall Pr G Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (Include apartment number, if in apartment house) Crane Highways Central Ave
Means of injury Pedestrian struck by car Injured at work?

23. SIGNATURE Deputy medical Examiner
M. D. or other
Address Upper Marlboro Md Date signed 1-7-47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

00790

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Rural - Bowie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Rural - Bowie
(If outside city or town limits, write RURAL and give nearest town)

Street No. Junction of Route 50 + Route 301
(If rural, give LOCATION)

2.(a) If veteran, name war: ~~1929~~ —

3.(a) FULL NAME: Mary Cordelia Gross

3.(b) Social Security Number: 229-26-0977

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Gross

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
23			...hrs. ...min.

9. Birthplace: Grundy - Buchanin Co. - Virginia
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Clarence Stevenson
13. Birthplace: Welch - McDowell Co - W. Va

MOTHER
14. Maiden name: Lydia Ward
15. Birthplace: Grundy - Buchanin Co - Virginia

16. Informant: Clarence Stevenson
Address: c/o C.W. Cox Gambrills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 18, 1947 (month) (day) (year)

Cemetery or crematory: Wards Cemetery

Location: Belgium Knob / Va

18. Funeral director: Merton Flaherty Sons

Address: Bowie Md

19. Jan. 16 1947 (Date rec'd by registrar) Mrs. J. M. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1947 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 8 1947, to January 15 1947

and that I last saw h.e.r. alive on January 15 1947

	DURATION
Immediate cause of death: Pulmunary Tuberculosis.	6 Years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward J Chenett M. D.
M. D. or other

Address: Gambrills Md Date signed: Jan 16, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

7-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00791

CERTIFICATE OF DEATH

Reg. Diat. No. 2450

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5006 Rittenhouse

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Felipe Guasp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Sullivan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 14, 1882

8. AGE: Years: 64 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Spain (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Retired

FATHER 12. Name: Arturo Guasp

13. Birthplace: Spain

MOTHER 14. Maiden name: Angela Vargara

15. Birthplace: Spain

16. Informant: Katherine A Hockendorf

Address: 4310 Baltimore Ave, Bladensburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 10. 1947 (month) (day) (year)

Cemetery or crematory: Mt olivet

Location: Washington D.C.

18. Funeral director: L Grasha sons

Address: Hyattsville md.

19. Jan 9 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1947, at 9 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Forestville md Date signed 1-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00792

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 18 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1412 - 9th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HELEN HAILEY

3.(b) Social Security Number: 578-09-8125

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Rufus Hailey

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 5, 1910

8. AGE: Years	Months	Days	If less than one day
36	3	17	..... hrs. ..... min.

9. Birthplace: St. George Co., South Carolina
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER
12. Name: Julius Haynes
13. Birthplace: St. Geo., South Carolina

MOTHER
14. Maiden name: Annie Smith
15. Birthplace: St. Geo., South Carolina

16. Informant: Deceased

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 24, 1947 (month) (day) (year)

Cemetery or crematory: Washington

Location: Ashaville, N.C., D. Can

18. Funeral director: Malvan T. Schey, Inc.

Address: 404-R St N.W.

19. Jan. 22, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 22 1947 at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from OCTOBER 3 1946, to JAN. 22 1947 and that I last saw h... E.R. alive on JAN. 22 1947

Immediate cause of death	DURATION
TUBERCULOSIS OF LUNGS	5 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. (M. D. or other)

Address: Glen Dale, Md Date signed: 1/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2430 = 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00793

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mos., 9 days.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 10 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1924 Lees Ct., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DAVID L. HARDY

3.(b) Social Security Number: 577-32-3880

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1927

8. AGE:	Years	Months	Days	If less than one day
	19	3	29	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Grocery Store

FATHER
12. Name: Frank Hardy
13. Birthplace:

MOTHER
14. Maiden name: Correnia Jackson
15. Birthplace:

16. Informant: Deceased
Address:

17. Removal Date thereof 1-29-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: to Washington.
Location:

18. Funeral director: Embrey Funeral Home
Address: 1238-20th St. N.W.

19. Jan. 28, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28, 1947 at 5:[illegible] A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 18, 1946, to Jan. 28, 1947, and that I last saw him alive on Jan. 27, 1947.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr. 4 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 1/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-2430 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b 06794

Reg. Dist. No. 2450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? four months.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 10 days, previously.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Dinwiddie
City or town: Petersburg.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503 Halifax Street.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harrison, Mrs. Addie Eutokah

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband ~~or wife~~: Thomas Herbert Harrison - Deceased 20 yrs.
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): 9-1-65

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	4	21		

9. Birthplace: Sussex County, Virginia -
(Town, county, and state)
10. Usual occupation: — homemaker.
11. Industry or business:

FATHER
12. Name: George R - Saunders.
13. Birthplace: ? Northcross.

MOTHER
14. Maiden name: Elizabeth - S. Saunders.
15. Birthplace: ?

16. Informant: Mrs. Alma Jordan
Address: 4411 Queensbury Dr. Riverdale, Md.
17. Burial, cremation, or removal. Which?: Burial Date thereof: 1/24/47 (month) (day) (year)
Cemetery or crematory: Blandford Cemetery
Location: Petersburg, Va.
18. Funeral director: W.W. Chambers Co.
Address: Riverdale - Md.
19. 1/23 1947 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-22-1947, at 5 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-1942, to 1-22-1947
and that I last saw h. on alive on 1-20-1947

Immediate cause of death	DURATION
Cerebral infarcto -	2 hours
Pulmonary congestion	3 hours
Due to: cerebral sclerosis-arteri	10 years
Due to: Generalized arteri-sclerosis	20 yrs.
Other conditions: Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. ~~VIOLENCE~~: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Shoemaker M.D. M. D. or other
Address: 8005 Woodbury Dr. Silver Spring, Md. Date signed: 1-22-47.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 00795

CERTIFICATE OF DEATH

Reg. Diat. No. 2421

1. PLACE OF DEATH:

County Prince George

City or town Suitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Suitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5301 - Meadowview Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Loran James Harrison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Vinnie T Harrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 6th 1879

8. AGE: Years 67 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Andrew Harrison

13. Birthplace Penn.

MOTHER 14. Maiden name Saphona Douglas

15. Birthplace Virginia

16. Informant Mrs Vinnie T Harrison

Address 5301 - Meadowview Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-47 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Maryland

18. Funeral director J. Wm Lee Sons Co

Address 800 - 4th St N E

19. 1-24 1947 (Date rec'd by registrar) Thos F Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1947 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 24 1947 and that I last saw h.. alive on Jan 23 1947

Immediate cause of death	DURATION
acute congestive heart failure.	1 day
and	
Due to Mild acute Hypertension	8 days
Due to Cardio Visceular Renal Disease	about 4 years
Other conditions Irritable Irregular heart edema Etc.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury no Injured at work?

23. SIGNATURE Chas E Hundley M. D. Coroner

Address Washington D C Date signed Jan 24 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C BC 00796

CERTIFICATE OF DEATH

Reg. Dist. No. 2390

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Yr.; 2 Mo. 5 D
Hospital, institution, or street address where death occurred:
Laurel Sanitarium, Laurel, Md
How long in hospital or institution? 2 Yr.; 2 Mo; 5 D

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5901 York Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Franklin Henderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Cleary Griffen
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26 - 1861

8. AGE: Years 85 | Months 7 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Cotton Merchant (retired)

11. Industry or business

FATHER
12. Name: Benjamin Henderson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Elizabeth Hann
15. Birthplace: Baltimore, Md.

16. Informant: Sanitarium Records
Address: Laurel San., Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/47 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Ave., Balto.

19. Funeral director: John C. Mitchell & Sons, Inc.

Address: 1900 Eutaw Place - Baltimore

19. 1/13 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 19 47, at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 19 46, to Jan. 11 19 47 and that I last saw him alive on Jan. 11 19 47

Immediate cause of death	DURATION
Cardiac Decompensation	5 days
Due to: General Arteriosclerosis	Chronic
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Wetherald, M.D. M. D. or other
Address: Laurel San., Laurel, Md. Date signed: 1/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97 - *

00743

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 hrs & 20"

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 44 hrs & 20"

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town 3415 Legation St. Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3415 Legation St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Pearl Edna Hoffmire (Taffner)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife He eeared

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1 1872

8. AGE:

Years	Months	Days	If less than one day
74	10	25	..... hrs. ..... min.

9. Birthplace New York.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Jacob Taffner

13. Birthplace New York

MOTHER

14. Maiden name Celia ?

15. Birthplace New York.

16. Informant Chart.

Address

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 1/26/47 (month) (day) (year)

Cemetery or crematory Memorial Park Cemetery

Location Syracuse, New York

18. Funeral director W.W. Chandler Co

Address Riverdale. md

Jan 26. 1947 (Date rec'd by registrar) James Sevrs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 19 47, at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 47, to Jan 25 19 47

and that I last saw h.. alive on Jan 25 19 47

Immediate cause of death	DURATION
a. Terminal Pneumonia	
Due to. Cardiac failure	
Due to. old age	
Other conditions. arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R Renshaw M. D. or other

Address 4404 Queensbury Rd. Riverdale Date signed 1-25-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00797

Reg. Diat. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 20 days
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1221 10th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MICHAEL K. HOWARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24, 1945

8. AGE: Years	Months	Days	If less than one day
1	8	3	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Baby
11. Industry or business:

FATHER
12. Name: Clyde D. Hines
13. Birthplace: Winston, North Carolina

MOTHER
14. Maiden name: Lucille B. Howard
15. Birthplace: Pageland, South Carolina

16. Informant: Lucille B. Howard, Mother
Address: 1221 10th St., N. W., Washington, D. C.

17. Burial, cremation, or removal. Which?: Removal — Date thereof: 1/29/47 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: Leon E. Messmore
Address: 1937-10 St. N.W.

19. (Date rec'd by registrar): Jan. 27, 1947 — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 27, 1947, at 6.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6, 1946, to Jan. 27, 1947
and that I last saw him alive on Jan 27, 1947

Immediate cause of death	DURATION
Tuberculous Meningitis	2 days
Due to: Pulmonary Tuberculosis (Primary Infection)	3 mo
Due to: Tuberculosis of left shoulder	1 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale Md. Date signed: 1/27/47

2-25

2-2430-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00798

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 12 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1331 5th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 4 months in Army

3.(a) FULL NAME: MORRIS JACKSON

3.(b) Social Security Number: 719-16-2617

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Agnes Jackson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1900

8. AGE: Years	Months	Days	If less than one day
46	9	18	hrs. min.

9. Birthplace: Chesterfield, South Carolina
(Town, county, and state)
10. Usual occupation: Elevator Operator
11. Industry or business:

FATHER
12. Name: Abe Jackson
13. Birthplace: Chesterfield, South Carolina

MOTHER
14. Maiden name: Betty Covington
15. Birthplace: Chesterfield, South Carolina

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal, Which?) Date thereof: Jany 14 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Wash. D.C.
18. Funeral director: Wm. T. Tolbert
Address: 1308-6th N.W. D-C
19. Jan. 13, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 13 1947 at 8 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-30-1946 1947, to 1-13 1947 and that I last saw him alive on 1-13 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	12 mos
Due to	
Due to	
Other conditions DIABETES MELLITUS	10 yrs 4 mos

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 1-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

2-24 30 — 2-40

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-6)

CERTIFICATE OF DEATH

Reg. Diat. No. 00799231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17½ hr
Hospital, institution, or street address) where death occurred:
Prince George General Hosp.
How long in hospital or institution? 17½ hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4300 - 31st St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wallace Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Emma Jackson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov - 23 - 1888

8. AGE: Years	Months	Days	If less than one day
58	1	22	hrs. min.

9. Birthplace: Alabama (Town, county, and state)
10. Usual occupation: Train Director
11. Industry or business: W. & L. Terminal

FATHER
12. Name: Albert Jackson
13. Birthplace: Alabama

MOTHER
14. Maiden name: Armanda
15. Birthplace:

16. Informant: W. Fe Emma
Address: 4300 - 31st St. Mt. Ranier

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 18 - 47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland - md

18. Funeral director: W. W. Chambers Co.
Address: 5801 Cleveland Ave. Riverdale Md.

19. 1/17 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 - 15 1947 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 - 14 1946 to 1 - 15 1947 and that I last saw him alive on 1 - 15 1947

Immediate cause of death	DURATION
Pyonephrosis Both Kidneys, Rupt Ureter Extravasation	10 days
Due to:	
Due to:	
Other conditions: Both Ureters transplanted into Colon because of Cancer Bladder (Include pregnancy within 3 months of death)	3 or 4 yrs

Major findings of operations:
Date of op.:
Autopsy results: Some
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Bruneyes M.D. (M. D. or other)
Address: Mt. Rainier md Date signed 1-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

00800

CERTIFICATE OF DEATH

Reg. Dist. No. 231 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George

City or town: Beverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 wks

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 7 wks

2. USUAL RESIDENCE (HOME) OF DECEASED. (For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 4104 Queensbury Rd (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Jones Mr. Gordon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Jones

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 3 August 1898

8. AGE: Years 48 | Months 5 | Days 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Owen Jones

FATHER — 13. Birthplace: N.Y.

MOTHER — 14. Maiden name: Mary Fitzpatrick

MOTHER — 15. Birthplace: N.Y.

16. Informant: Hospital Records

Address: Prince Georges Hospital

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 8. 1947 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md

18. Funeral director: J Gaschen sons

Address: Hyattsville Md

19. 1/7 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-7 1947, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jan 7 1947

and that I last saw h... alive on Jan 7 1947

Immediate cause of death	DURATION
Due to: Cardio Vascular Renal Glomerulonephritis	
Due to:	
Other conditions: Cardiac Hypertrophy Hypertensive Predisposition	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hyattsville Md Date signed 1-8-47

00801

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr Geo
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Girl Keys

3. (b) Social Security Number

4. Sex F
5. Color or race Bk
6.(a) Single, married, widowed, or divorced —
6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Jan 12, 1947
8. AGE: Years — Months Days If less than one day 8 hrs. ... min.
9. Birthplace Warren Hosp Laurel Md
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Keefer G. Keys
13. Birthplace Laurel Md
MOTHER 14. Maiden name Gwendoline Hayes
15. Birthplace England
16. Informant Keefer G. Keys
Address Laurel Md
17. Burial Date thereof Jan 13 1947
(Burial, cremation, or removal. Which) (month) (day) (year)
Cemetery or crematory Ivy Hill
Location Laurel Md
18. Funeral director Hewitt Donaldson
Address Laurel Md
19 Jan 13 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947, at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12/47 19 , to 1/12/47 19
and that I last saw her alive on 1/12/47 19
Immediate cause of death Prematurity

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J M Warren M.D.
M. D. or other
Address Laurel Date signed 1/13/47

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

126 ★ 00802

Reg. Dist. No. 243, 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 5 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1414 Carrollburg St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: PERCY E. KYLES

3.(b) Social Security Number: 084-05-0525

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Separated

6.(b) Name of husband or wife: Helen Kyles

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 20, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	22	..... hrs. ..... min.

8. Birthplace: Ashville, North Carolina (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business:

FATHER — 12. Name: Albert Kyles

13. Birthplace: Ashville, North Carolina

MOTHER — 14. Maiden name: Clara Britton

15. Birthplace: Ashville, North Carolina

16. Informant: Deceased

Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) 1-13-47

Cemetery or crematory: to Wash. D.C.

Location:

18. Funeral director: Eugene Ford

Address: 1215-4½ St. S.W.

19. (Date rec'd by registrar) 1-13-47 19 Rowland L. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 19 47 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 19 46 to Jan. 12 19 47 and that I last saw h.. alive on Jan. 12 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mo.
Due to: Diabetes Mellitus	8 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 1-12-47

1-25

2-[2430 —— 1 — 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00803

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince George
City or town Near Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Bowie Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. Bowie-Laurel Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Aloysius Lammers

3.(b) Social Security Number 212-14-5871

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Nov 18, 1912

8. AGE: Years 34 Months 2 Days 1 If less than one day ... hrs. ... min.

9. Birthplace Laurel, Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business U. S. Govt.

FATHER
12. Name Arnold Lammers
13. Birthplace Germany

MOTHER
14. Maiden name Mary A. Otten
15. Birthplace Elkridge, Md

16. Informant Charles Lammers
Address Laurel, Md

17. Burial Date thereof Jan 22, 1947
(Burial, cremation, or removal (Which?)) (month) (day) (year)
Cemetery or crematory St. Marys
Location Laurel, Md.
18. Funeral director DeWitt Donaldson
Address Laurel, Md.

19. Jan 21 1946 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1947, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Hemorrhage and shock

Due to: Fracture of base of skull
Crushed Chest

Due to:

DURATION

Other conditions: Compound comminuted fracture of upper arm near shoulder
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1-19-47
Where did injury occur? Laurel P. G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where) Bowie-Laurel Rd
Means of injury [illegible]

Deputy medical Examiner

23. SIGNATURE James I. Boyd
M. D. or other
Address Forestville Md Date signed 1-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136

Reg. Dist. No. 06802431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale Sanatorium
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 531 48th Place, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: JOHN R. LEWIS.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1887

8. AGE: Years	Months	Days	If less than one day
59	10	13	hrs. min.

8. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Departmental Policeman

11. Industry or business:

FATHER
12. Name: Charles Lewis
13. Birthplace: Leesburg, Virginia

MOTHER
14. Maiden name: Elizabeth (?)
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Jan 23, 1947

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Henry S. Washington & Sons

Address: 467 N St. N.E.

19. (Date rec'd by registrar) Jan 23, 1947 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23rd 1947, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2nd 1947, to January 23rd 1947

and that I last saw him alive on January 23rd 1947

Immediate cause of death — DURATION

Pulmonary Tuberculosis — 3 mos 23 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-2439 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00805

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 2450

1. PLACE OF DEATH:
County Mt. Rainier
City or town P. Georges (If outside city or town limits, write RURAL and give nearest town)
How long in above-place of death?
Hospital, Institution, or street address where death occurred:
4304-28th Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Pennsylvania County Montour
City or town Danville (If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 4 (If rurel, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Love

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife Edward Love
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1874

8. AGE: Years 72 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, County, and state)
10. Usual occupation House wife
11. Industry or business Own Home
FATHER 12. Name Henry L Confer
13. Birthplace Penn.
MOTHER 14. Maiden name Sarah A Culp
15. Birthplace Penn
16. Informant Mrs Ascon Lee Pennington
Address 4304-28th Place, Mt Rainier
17. Transportation (Burial, cremation, or removal. Which?) Date thereof Jan 9, 1947 (month) (day) (year)
Cemetery or crematory Danville
Location Pennsylvania
18. Funeral director F Gusti's sons
Address Hyattsville Md.
Jan 9 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1947, at 12:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underliee the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical Examiner
23. SIGNATURE James E Zapf M. D. or other
Address Frostburg Md. Date signed 1-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-35

00806

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 2320

1. PLACE OF DEATH:
County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter Makel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Carrie Bell Makel
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): unknown 1873

8. AGE: Years	Months	Days	If less than one day
73 ??			...hrs. ...min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Madboro High school

FATHER
12. Name: —
13. Birthplace

MOTHER
14. Maiden name: Jane Makel
15. Birthplace

16. Informant: Carrie Bell Makel
Address: Upper Marlboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7 1947 (month) (day) (year)
Cemetery or crematory: Mount
Location: Marlboro Md
18. Funeral director: J. B. Johnson
Address: Upper Marlboro Md

19. Jan 7 1947 (Date rec'd by registrar) R. Duke Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/4 1947 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/4/47 19... to 1/4/47 19... and that I last saw h...m alive on 1/4/47 19...

Immediate cause of death	DURATION
Coronary thrombosis	16 hrs.
Due to: Arterial Hypertension	unknown
Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Oswald W. Hoffler M.D. (M. D. or other)
Address: Upper Marlboro, Md. Date signed: 1/4/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00807 2455

Reg. Diat. No.

1. PLACE OF DEATH:
County Prince Geo. Co
City or town Riverdale - md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md County Prince Geo Co
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4575 - Madison St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Florence McCormick

3. (b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: John R. McCormick
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept. 24 - 1871
8. AGE: Years: 75 Months: 3 Days: 19 If less than one day ..... hrs. ..... min.
9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Augustus E. Berkeley
13. Birthplace: Germany
MOTHER 14. Maiden name: Mary E. Hoot Kamp
15. Birthplace: Wash. D.C.
16. Informant: Gertrude Troy
Address 4575 Madison St. Riverdale, md
17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-16-47 (month) (day) (year)
Cemetery or crematory Columbia Gardens Cemetery
Location Arlington - Va
18. Funeral director W W Chambers Co
Address Riverdale - md
19. Jan 15 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1947 at 3 50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1945 to Jan 13 1947 and that I last saw h.er alive on 1-13 1947

Immediate cause of death	DURATION
Hypertensive Heart and Kidney disease	
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dewey Hagner M.D. M. D. or other
Address 3717 - 38th St. Date signed 1/13/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 00808

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bowie (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ERNST MERKEL

3.(b) Social Security Number: 578-03-1880

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frieda Merkel
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): Nov 1, 1879

8. AGE: Years	Months	Days	If less than one day
67	2	1	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Retired - Painter
11. Industry or business
FATHER 12. Name: August Merkel
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Minnie
MOTHER 15. Birthplace: Germany
16. Informant: Mrs. H. D. Bartholomee
Address: 5110 Leeds Ave. Baltimore (27)
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 23 1947 (month) (day) (year)
Cemetery or crematory: Lutheran Church Cemetery
Location: Bowie, Maryland
18. Funeral director: Lloyd Kaiser Inc.
Address: 381 Main St. Laurel, Md.
19. January 21 1947 (Date rec'd by registrar) Mrs. J. W. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1947 at 9:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1947 to Jan 20 1947 and that I last saw h alive on Jan 20 1947

	DURATION
Immediate cause of death: Bronchopneumonia	3 Days
Due to: Hypertension and Arteriosclerotic Heart and Renal Disease	1 2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J M Warren MD M. D. or other
Address: Laurel Date signed: 1/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06809

83a

Reg. Diat. No. 2450

1. PLACE OF DEATH:
County PRINCE GEORGE
City or town RURAL HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ yrs.
Hospital, institution, or street address where death occurred:
MOTHER JONES REST HOME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Rural Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Riggs Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rt. REV. PHILO LOAS MILLS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

8.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 24, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	3	hrs. min.

9. Birthplace HARTFORD, CONN. (Town, county, and state)
10. Usual occupation PRIEST.
11. Industry or business
FATHER 12. Name LAWRENCE H. MILLS
13. Birthplace NEW. JERSEY
MOTHER 14. Maiden name MARIE B. SWAN
15. Birthplace NEW. JERSEY
16. Informant LILLIE MAY BURGESS
Address RIGGS ROAD, Hyattsville E. Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan 17 1947 (month) (day) (year)
Cemetery or crematory
Location 2901-14th St. N.W. Wash. D.C.
18. Funeral director L. H. Hines Co.
Address 2901-14th St. N.W. Wash. D.C.
19. Jan 27 1947 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Jan 1947 at 7 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Jan. 1947 to 27 Jan 1947 and that I last saw h[illegible] alive on 25 Jan. 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage.	6 Days
Due to: Senile Arteriosclerosis	Several Years
Due to:	
Other conditions: Pulmonic Upper Lobe Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. B. Cullen M.D.
M. D. or other
Address Takoma Park, Md. Date signed 27 Jan 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00810

CERTIFICATE OF DEATH

Reg. Diat. No. 2450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville Md

(If outside city or towo limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Sacred Heart Home

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State D C County

City or town Washington D C

(If outside city or towu limits, write RURAL and give nearest town)

Street No. 1232 2nd St N E D C

(If rural, give LOCATION)

2.(o) If veleran, name war

3. (a) FULL NAME Annie E Monday.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife John monday

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1864

8. AGE: Years	Months	Days	If less than one day
82	10	4	hrs. min.

9. Birthplace Washington D C (Town, coouty, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name John Riley

13. Birthplace Ireland

MOTHER 14. Malden name Ellen monatte

15. Birthplace Ireland

16. Intormant Sacred Heart Home Records

Address Hyattsville md.

17. Burial (Borial, cremation, or removal. Which?) Date thereof Jan 8 1947 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Washington D.C.

18. Funeral director J Wm Lee Long & Co

Address 3004 4th St N E D.C.

19. Jan 7 1947 (Date rec'd by registrar) James Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1947, at 3:05 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1947 to Jan 5 1947 and that I last saw h.r alive on Jan 4 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
acute Colic failure	18 hrs
Due to Arthris Sclerotic Heart Disease	yrs
Due to Generalized Atherosclerosis	years
Other conditions Senile Changes	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should ba charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or towo) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G W Burch M. D. or other

Address 208 Md Ave N E Date signed Jan 6 47

1-3

Evidence for the change of age is shown on G 108 1/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00811

136

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 23 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1120 22nd Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: LELA MOODY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Authoniel Moody
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 14, 1908

8. AGE: Years	Months	Days	If less than one day
38	9	24	..... hrs. ..... min.

9. Birthplace: Greennill, South Carolina
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Joseph Butler
13. Birthplace: Greennill, South Carolina

MOTHER
14. Maiden name: Sue ?
15. Birthplace: Greennill, South Carolina

16. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan 9, 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.
18. Funeral director: J. C. Janifer
Address: 1120 22 St NW
19. Jan 8 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8 1947, at 10:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1946, to Jan. 5 1947
and that I last saw her alive on Jan. 8 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D., or other
Address: Glenn Dale, Md. Date signed: 1-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2430 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00812

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Pr. Georges
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 year
Hospital, Institution, or street address where death occurred: 7087 Ritchie Road
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Georges
City or town: Ritchie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7087 Ritchie Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mable Irene Moran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband: Joseph Henry Moran
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Feb 18 1900

8. AGE: Years	Months	Days	If less than one day
46	10		hrs. mio.

9. Birthplace: Upper Marlboro Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own Home

FATHER
12. Name: W. Eugene Norfolk
13. Birthplace: Upper Marlboro Md

MOTHER
14. Maiden name: Ruth Brown
15. Birthplace: Upper Marlboro Md

16. Informant: Mr. Jos Henry Moran
Address: 7087 Ritchie R.A.S.E. Wash 19 D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 6 47 (month) (day) (year)
Cemetery or crematory: Epiphany
Location: Forestville Md
18. Funeral director: Ritchie Brothers
Address: Upper Marlboro Md
19. Jan 4 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 3 1947 and that I last saw h.. alive on Jan 2 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	6 days
Due to: Essential hypertension	7 Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Suit Ritchie MD (M. D. or other)
Address: 6906 Ritchie Road SE Washington 19 D.C. Date signed: Jan 3 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13la

00813

CERTIFICATE OF DEATH

Reg. Dist. No. 2421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: District Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: Allentown Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Geo.

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6780 Allentown Road

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: HARRY HOWARD MORGAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Myrtle D. Morgan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 25 1894

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace: Steubenville Ohio (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Navy Yard

FATHER

12. Name: Orlando Morgan

13. Birthplace: Ohio

MOTHER

14. Maiden name: Unknown

15. Birthplace: Ohio

16. Informant: Mrs. Myrtle D. Morgan

Address: 6780 Allentown Rd. Wash. 20 DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-47 (month) (day) (year)

Cemetery or crematory: Arlington Natl.

Location: Arlington Va.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St. S.E.

19. 1-2-47 (Date rec'd by registrar) 19..... Thos S. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 1947, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive Heart Failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Deputy medical Examiner James A. Boyd M. D. or other

Address: Forestville Md. Date signed 1-2-47

2-2420-1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00814

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 239 0

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Yr.: 4 M.: 0 D.
Hospital, institution, or street address where death occurred: Laurel Sanitarium, Laurel, Maryland
How long in hospital or institution? 1 Yr.: 4 M.: 0 D.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 21 Michigan Ave N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME James Charles Mulvihill

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 28 - 1885
8. AGE: Years 61 | Months 8 | Days 22 | If less than one day ... hrs. ... min.
9. Birthplace: Washington, D. C
(Town, county, and state)
10. Usual occupation: Retail Storekeeper - retired - Sept. 1944
11. Industry or business:

FATHER
12. Name: Patrick Mulvihill
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Walsh
15. Birthplace: Ireland

16. Informant: Sanitarium Records
Address: Laurel Sanitarium, Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 - 21 - 47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D C.
18. Funeral director: The S H Hines Co
Address: 2901 14th St N.W. Washington - D.C.
19. Jan 19 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1947, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 1945, to Jan. 19 1947
and that I last saw him alive on January 19 1947

	DURATION
Immediate cause of death: Cardiac decompensation following convulsion	1/19/47
Due to: Chronic Myocarditis, before	9/19/45
Due to: Convulsions following cerebral hemorrhage	Sept. 1944
Other conditions (Include pregnancy within 3 months of death): General Arterio-Sclerosis	Unk.

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John L Wethered M. D. (M. D. or other)
Address: Laurel Sanitarium, Laurel, Maryland
Date signed: 1/19/47

1-35

Evidence for the change of year of birth is shown on G 108 1/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b ★ 00815

CERTIFICATE OF DEATH

Reg. Diat. No. 2421

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Bradbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
5210 Shadyside Avenue, S.E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: BRADBURY, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5210 SHADYSIDE AVENUE, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: THOMAS NAREM

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	MARRIED

6.(b) Name of husband or wife: Mrs. Jeanette Elizabeth Narem
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DECEMBER 19th, ~~1873~~ 1874

8. AGE: Years	Months	Days	If less than one day
72 Years			hrs. min.

9. Birthplace: NORWAY (Town, county, and state)
10. Usual occupation: CARPENTER
11. Industry or business:

FATHER
12. Name: Theodore Narem
13. Birthplace: Norway

MOTHER
14. Maiden name: Kirsten Narem
15. Birthplace: Norway

18. Informant: Mrs. Jeanette Elizabeth Narem
Address: 5210 Shadyside Avenue, Bradbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN. 23rd, 1947 (month) (day) (year)
Cemetery or crematory: CEDAR HILL CEMETERY
Location: SUITLAND ROAD, S.E.-WASH. D.C.

18. Funeral director: Martin W. Hyson Co.
Address: 1300 N. STREET, N.W. - WASH. D.C.

19. 1-21-47 (Date rec'd by registrar) Thos S Tuffle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 21st, 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 15 1946, to 1-21- 1947
and that I last saw h.i.m. alive on 1-6- 1947

Immediate cause of death: Carcinoma of Stomach plus Malnutrition and Dyspnea — DURATION: 3 months

Due to: Metastasis — 3 months

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Ca Stomach Metastasis to Liver
Date of op. 11-26-46
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. L. Ruby M. D. or other
Address: 150 3/4 Good Hope Rd., S.E., D.C. Date signed 1-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-25

2-2420 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00816

932

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
Prince Georges Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6109 Arbor St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Naylor Lucia R

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife Henry Naylor
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 49 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace New York (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Wesley Robertson
13. Birthplace New York
MOTHER 14. Maiden name Mame Arnold
15. Birthplace Canada
16. Informant Husband
Address Same
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1947 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem
Location Bladensburg Md.
18. Funeral director Lloyd W. Hartley
Address 301 E. Capitol St. Wash D C
19. 1/27 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-1947, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10 1947, to 1-27- 1947 and that I last saw her alive on 1-26-1947

Immediate cause of death	DURATION
Hypertension	
Heart + kidney disease	
Pneumonia passophuring	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George Hagan M. D. or other
Address 3717-38th St Date signed

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01035

Reg. Diat. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. Victory House, 9th St., N. W.,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME WALTER P. NOLAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Theresa Howard

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): January 14, 1894

8. AGE: Years	Months	Days	If less than one day
53	53	0	16	....hrs. ....min.

9. Birthplace: Dublin, Ireland

(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Newspapers

FATHER 12. Name: Luke Nolan

FATHER 13. Birthplace: Dublin, Ireland

MOTHER 14. Maiden name: Margaret O'Brien

MOTHER 15. Birthplace: Dublin, Ireland

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal, Which?) Date thereof 2/3/47 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director: A. W. Chambers Co

Address 1700 Eighteenth St. N.W.

19. Jan 30 1947 Rowland S. Phillips

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30, 1947, at 1.35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 22 1947, to JAN. 30 1947, and that I last saw h.... alive on JAN. 30 1947

Immediate cause of death	DURATION
TUBERCULOSIS OF LUNGS	3 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D., M. D. or other

Address: Glenn Dale, Md. Date signed 1-30-47

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00817

46f

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Days
Hospital, Institution, or street address where death occurred: Prince Georges Gen Hosp.
How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Decatur Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5306 Tilden Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edward M. Nutty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	M

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): -1883

8. AGE: Years: 64 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mrs. Georgia Pelkey
Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Bladensburg Rd. & D.C. Line
18. Funeral director: Wm. J. Malley
Address: 3200 - R.I. Ave. Mt. Rainier, Md.
19. 1/17 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1947 at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1946 to Jan 15 1947
and that I last saw him alive on Jan 15 1947

	DURATION
Immediate cause of death: Cardiac failure	
with extreme Prostration	
Due to: Carcinoma of Liver	
Due to:	
Other conditions: about 1yr duration	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Carcinoma of Liver
PHYSICIAN: Please underline the cause to which death should be charged statistically.

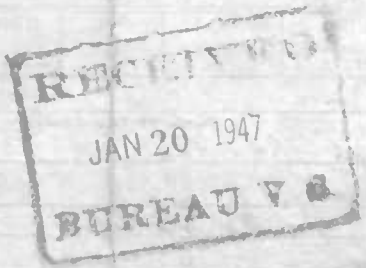
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jasper P. Garden Jr. M.D.
M. D. or other
Address: Hyattsville, Md. Date signed: 1/15/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170C ★ 00818

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Immanent
Hospital, institution, or street address where death occurred:
Crane Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheltenham
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Murphy Oliver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Cora Taylor Oliver
6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) February 24, 1906

8. AGE: Years	Months	Days	If less than one day
40	10	8	hrs. min.

9. Birthplace Cheltenham Md
(Town, county, and state)
10. Usual occupation Fremason
11. Industry or business Andrews Field
FATHER 12. Name James T. Oliver
13. Birthplace Maryland
MOTHER 14. Maiden name Ethel Pyles
15. Birthplace Maryland
16. Informant Mrs. Cora Taylor Oliver
Address Cheltenham, Md
17. Burial (Burial, cremation, or removal) Date thereof 1-4-47 (month) (day) (year)
Cemetery or crematory Cheltenham Methodist
Location Cheltenham, Md.
18. Funeral director Pitchie Bros
Address Upper Marlboro, Md.
19. 1-4-47 19 (Date rec'd by registrar) F. H. Billingsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 19 47 at 7 39 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
1. Hemorrhage and shock	
Due to Fracture skull, crushed face, crushed abdomen	
Due to Crushed pelvis	
Compound Comminuted fracture Both legs, multiple	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1-2-47
Where did injury occur? Cheltenham P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Crane Highway
Manner of injury Pedestrian struck by auto Injured at work? No
Deputy Medical Examiner
23. SIGNATURE M. D. or other
Address Forestville Md Date signed 1-3-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00814

CERTIFICATE OF DEATH

Reg. Dist. No. 2432

1. PLACE OF DEATH:

County: Prince George's

City or town: Mitchellville - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Mitchellville, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Frank Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: About 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Anne Arundel County
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: John Ingalls
Address: Mitchellville, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1-2-47
(month) (day) (year)

Cemetery or crematory: Carroll Chapel

Location: Mitchellville, Md

18. Funeral director: Clarence Forecare

Address: Mitchellville, Md.

19. Jan 1 1947 (Date rec'd by registrar) Louise H Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1947 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1946 to Jan 1 1947 and that I last saw him alive on Dec 29 1946

Immediate cause of death	DURATION
Congestive Heart Failure	2 months
Due to: Myocarditis	10 yrs
Due to:	
Other conditions: Arteriosclerosis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James E. Lasseter, M. D. or other

Address: Upper Marlboro, Md. Date signed: 1-1-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2430 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00820

136

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 5 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4104 13th Place, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: PERRY, CATHERINE B.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles B. Perry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1875

8. AGE: Years	Months	Days	If less than one day
71	9	12	hrs. min.

9. Birthplace: Richmondville, New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: J. C. Biret
13. Birthplace: Germany

MOTHER
14. Maiden name: Sara C. Gould
15. Birthplace: New York

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 24, 1947 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D. C.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St. N.W. Wash. D.C.

19. Jan. 21, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21, 1947 at 6:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15 1946 to 1/21 1947 and that I last saw h... alive on 1/21 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	31 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2480 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b 0082

Reg. Dist. No. 2371

1. PLACE OF DEATH:
County: Prince Georges
City or town: Naylor Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Naylor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin F. Rawlings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Evaline Rawlings
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): August 15 - 1904

8. AGE: Years: 42 Months: 4 Days: 27 If less than one day: hrs. min.

9. Birthplace: Nottingham, Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Wallace Rawlings
13. Birthplace: Nottingham, Md

MOTHER
14. Maiden name: Dorothy Boswell
15. Birthplace: Nottingham Md

16. Informant: Percy A. Hall
Address: Westwood, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 15 47 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro Md

18. Funeral director: Ritchie Bros
Address: Upper Marlboro Md

19. Jan 14 1947 (Date rec'd by registrar) James B. Naylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Jan 12 1947 and that I last saw him alive on Jan 12 1947

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John E. Bowers, M.D. (M. D. or other)
Address: Brandywine, Md Date signed: 1/13/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

2-2370 —— 1—10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06822

13la

CERTIFICATE OF DEATH

Reg. Diat. No. 2300

1. PLACE OF DEATH:

County: Prince Georges

City or town: Ammendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: Retired Priests and Brothers Mother Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Ammendale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Retired Priests and Brothers Mother Home

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Gabriel Remigius

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1898

8. AGE: Years: 48 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Jersey City, N. J. (Town, county, and state)

10. Usual occupation: Catholic Brother

11. Industry or business: Retired

FATHER — 12. Name: Francis Patrick Hayes

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Ellen Kane

MOTHER — 15. Birthplace: Ireland.

18. Informant: Brother Elias

Address: Ammendale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-28-47 (month) (day) (year)

Cemetery or crematory: Brothers Cemetery

Location: Ammendale - Md

18. Funeral director: Lowchambers Co

Address: Riverdale - Md.

19. January 27th 1947 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1947, at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions: Epileptic	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE: James J. Boyd M. D. (Other)

Address: Forestville Md Date signed 1-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

00823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 2421

1. PLACE OF DEATH:

County Prince Georges

City or town Suitland

(If outside city or towo limits, write RURAL ond give nearest towo)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

4940 Suitland Rd S E

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infoots give residooce of mother)

State Maryland County Prince Georges

City or town Suitland

(If outside city or town limits, write RURAL and givo nearest town)

Street No. 4940 Suitland Road S E

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ira Hay Reynolds

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Anna Eliza Reynolds

6.(c) If alive, give age ____ years

7. Birth dafn of deceased (mo., day, yr.) June 15, 1860

8. AGE:

Years	Months	Days	If less than one day
86	7	9	____ hrs. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

FATHER 12. Name John Reynolds

13. Birthplace Virginia

MOTHER 14. Maiden name Harriett Motherhead

15. Birthplace Virginia

16. Informant Ada Hawes

Address 2912 - Nelson Place S E Washington D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1947 (month) (day) (year)

Cemetery or crematory Henderson Methodist Ch. Cem.

Location Callao, Virginia

18. Funeral director James T. Ryan, Inc.

Address 317 Penna. Ave. S. E.

19. 1/25 1947 Thos. D. Griffith Registrar

(Date rec'd by registror)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947, at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1947 to January 24 1947 and that I last saw h alive on January 22 1947

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Incindo pregnoncy within 3 months of death)

Major fiodings of operatioos ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fiit in the following:

Accidenf, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured af home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE James T. Boyd M. D. or other

Address Forestville Md Date signed 1-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-25

2-2420-1-10

Evidence for the change of age is shown on G 108 1/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

00824

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 55 hours
Hospital, institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 23 hours 55 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C. County: Washington
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 1940 - 3rd St. N.E. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Richardson
3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	M

6.(b) Name of husband or wife: Caddy Richardson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 29, 1888

8. AGE: Years 57 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Virginia (town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER — 12. Name: L. A. Richardson
13. Birthplace: Va.
MOTHER — 14. Maiden name: ?
15. Birthplace: ?
16. Informant: William Richardson
Address: 1940 - 3rd St N.E. Wash, D.C
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Cottage City, Md.
18. Funeral director: W. Warren Haltaverll
Address: 3619 - 14th St. N.W. Wash. D.C.
19. 1/22 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-21 1947, at 3 40 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-10 1947, to 1-21 1947
and that I last saw h[illegible] alive on 1-21 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Diabetes	6 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Cerebral Hemorrhage - Edema of Brain
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George Hagerty M. D. or other
Address: 3117 - 38th St. Cam Date signed: 1-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

00825

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 - 50th St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: ROBERTSON, SUSAN E.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Winston Robertson

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1925

8. AGE: Years	Months	Days	If less than one day
21	4	16	..... hrs. ..... min.

9. Birthplace: Orange, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Lenwood Howard
13. Birthplace: Orange, Virginia

MOTHER
14. Maiden name: Rebecca E. Howard
15. Birthplace: Orange, Virginia

16. Informant: Deceased
Address:

17. Jan. 24, 1947 Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1947 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location:

18. Funeral director: Ruth Dabney

Address: 472-M-St. N.W.

19. Jan 24 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24 1947, at 8:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/23 1946 to 1/24/47 1947

and that I last saw h. alive on 1/24 1947

	DURATION
Immediate cause of death: pulmonary Tuberculosis	6 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md Date signed: 1-24-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2430 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00826

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 14 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1812 12th St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LOUISE ROBINSON

3.(b) Social Security Number: 5783 U 6003

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James M. Robinson

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): December 23, 1919

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
27	0	26		

9. Birthplace: Newbury, South Carolina (Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: Garfield Hospital

FATHER — 12. Name: Monk Lindsey

FATHER — 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Nancy Williams

MOTHER — 15. Birthplace: South Carolina

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/20/47 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: Jafet F. Williams

Address: 1702 - 12th St. N.W.

19. Jan. 19, 1947 (Date rec'd by registrar) Rowland S. Plutjes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1947, at 7:37 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1946 to Jan 19 1947 and that I last saw h... alive on Jan 19 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	13 mo
Due to: Tuberculosis Spine	13 mo
Due to: Tuberculosis Pulm	13 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 1/19/47

2-25

2-2430 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 0082 245

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo County
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5005 40th Place-
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: Laura Simpson

3.(b) Social Security Number: --

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John Simpson
6.(c) If alive, give age: ---
7. Birth date of deceased (mo., day, yr.): February 13, 1857-

8. AGE: Years	Months	Days	If less than one day
89	11	3	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: William Banes
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Lydia Ann Bloom
15. Birthplace: Pennsylvania

16. Informant: Miss Elizabeth Banes
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18, 1947. (month) (day) (year)
Cemetery or crematory: North Fork
Location: Virginia.

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland.

19. Jan. 17" 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1947, at 2am.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Jan 16 1947
and that I last saw her alive on Jan 15 1947

Immediate cause of death	DURATION
Cardiac failure	
Due to Arterio sclerosis	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Dwight W. Fahrner M.D. M. D. or other
Address: Hyattsville Md Date signed: 1-16-47

1 - 25

2 - 2450 - 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 L ★ 1 00828

Reg. Dist. No. 2310

1. PLACE OF DEATH:
County: Prince George
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6001 Annapolis Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie M. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
42	Colored	Married

6.(b) Name of husband or wife: John W. Smith
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Feby 28, 1904

8. AGE: Years: 42 Months: 10 Days: 25 If less than one day: hrs. min.

9. Birthplace: Prince George Co. Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: Not known
13. Birthplace: " "

MOTHER 14. Maiden name: Jennie Bailey
15. Birthplace: Maryland

16. Informant: Margaret E. Williams
Address: 6001 Annapolis Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28, 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Washington D.C.

18. Funeral director: J. Ernest Kerns Co.
Address: 1432 Good St. N.W.

19. 1/23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1947, at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1946, to Jan 23 1947
and that I last saw h.. alive on Jan 22 1947

Immediate cause of death	DURATION
Carcinoma Uterus	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Wells Jr. M.D. M. D. or other
Address: 1161 First St NW Washington DC Date signed: Jan 23 1947

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

15b 00829

Reg. Dist. No. 2431

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos., 9 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 465 New York Ave. N. W.,
(If rural, give location)
2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARD STEWARD SMITH

3.(b) Social Security Number: 219-16-1397

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
26	9	9		

9. Birthplace: Mayo, Maryland (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Roominghouse

FATHER
12. Name: William S. Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elnora Smith
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1947 (month) (day) (year)
Cemetery or crematory: St. Mark's
Location: Mayo, Anne Arundel Co. Md.
18. Funeral director: Jas. R. Johnson
Address: Jas. R. Johnson Glenn Dale Md.

19. Jan. 9, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1946, to Jan. 9 1947
and that I last saw him alive on Jan. 9, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	8 mo.
Due to: Diabetes Mellitus	3½ yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 1-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-2430 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

CERTIFICATE OF DEATH

00830

Reg. Diat. No. 2450

1. PLACE OF DEATH:
County Pro Geo co
City or town University Park md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pro Geo co
City or town University Park md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4320 Clagett Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rebecca Mary Stoner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife David B. Stoner

6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) July 4. 1853

8. AGE:

Years	Months	Days	If less than one day
93	6	23	hrs. min.

9. Birthplace Penna (Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name John Emrick
13. Birthplace Penna

MOTHER
14. Maiden name Sarah Slick
15. Birthplace Penna

16. Informant Mrs Oscar Eaton
Address University Park Md

17. Burial Date thereof Jan 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fisherton Cemetery
Location Fisherton Penna

16. Funeral director F Gaches sons
Address Hyattsville Md.

Jan 27 1947 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27. 1947 at 1.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1946 to Jan 27 1947
and that I last saw her alive on January 20 1947

Immediate cause of death	DURATION
Pulmonary Embolism	1 hr
Due to Advanced arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis H Mendel MD
M. D. or other
Address College Park Md Date signed 1/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of year of birth isshown on G 108 1/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00831

53

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Camp Hill, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 weeks
Hospital, institution, or street address where death occurred: 7508 Blaine Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Carmody Hill, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7508 Blaine St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Ashton Stuart, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 31, 1867

8. AGE: Years	Months	Days	If less than one day
80	4	10	5 hrs. ..... min.

9. Birthplace: Prince Wm. Co., Va.
(Town, county, and state)
10. Usual occupation: Foreman, Railroad
11. Industry or business: "
12. Name of father: George Stuart
13. Birthplace of father: Prince Wm. Co., Va.
14. Maiden name of mother: Mary Stuart
15. Birthplace of mother: Prince Wm. Co., Va.
16. Informant: W. F. Stuart
Address: 5630 North 8th St, Arlington, Va.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 11-47 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: C. J. Clues
Address: Arlington, Va
19. Jan. 11 1947 (Date rec'd by registrar) Carrie F. Campbell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11th 1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26th 1946 to Jan. 11, 1947 and that I last saw him alive on Jan. 8th 1947

Immediate cause of death: Carcinoma of left ear — DURATION: 14 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. Apgar M. D. or other
Address: Fort Pleasant, Md. Date signed: Jan. 11/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00832

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 3 mos., 24 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 3 mos., 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3218 13th Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THEODORE STUKES

3.(b) Social Security Number: 250-03-1498

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Catherine Stukes

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): July 5, 1918

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
28	6	15		

9. Birthplace: Clarington County, South Carolina
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business:

FATHER — 12. Name: July Stukes

13. Birthplace: Clarington Co., South Carolina

MOTHER — 14. Maiden name: Emma L. Bozier

15. Birthplace: Clarington Co., South Carolina

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 20, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Malvar & Sickey Inc

Address: 424 R St. N. W.

19. Jan. 20, 1947 (Date rec'd by registrar) Rowland S. Philips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20, 1947, at 3:2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/25/44, to 1/20/47, and that I last saw him alive on 1/20/47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yr 6 mo
Emphysema - Tuberculous	27 mo 26 da
Due to: Tuberculosis Vertebrae	27 mo 15 da
Tuberculosis Kidney	14 mo 11 da
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale Md. Date signed: 1/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2 - 2430 — 2 - 12

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00833

Reg. Dist. No. 2431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mos., 5 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 5 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 232 G. Street, N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DAVID D. TAYLOR

3.(b) Social Security Number: 579-05-7170

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lulu Taylor

6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): March 5, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	10	17		

9. Birthplace: Wilson, North Carolina
(Town, county, and state)

10. Usual occupation: Moulder

11. Industry or business: Buffalo Aircraft Co.,

FATHER
12. Name: Joe Taylor
13. Birthplace: Wilson, North Carolina

MOTHER
14. Maiden name: Mollie Sims
15. Birthplace: Wilson, North Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 23, 1947 (month) (day) (year)

Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: J. T. Stewart
Address: 230 A St. N.E.

19. Jan. 22, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 22nd 1947, at 5-45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16th 1946, to Jany 22nd 1947 and that I last saw him alive on Jany 22nd 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 yr. 4 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed 1/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

179X

00834

CERTIFICATE OF DEATH

[X] Reg. Dist. No. 2451

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, Institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4203 Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Floyd Hamilton Tincherry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Carter Tincherry
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Dec 25. 1909

8. AGE:

Years	Months	Days	If less than one day
37	0	15	hrs. min.

9. Birthplace: Greensboro (Town, county, and state) North Carolina
10. Usual occupation: Sign Writer
11. Industry or business

FATHER
12. Name: Atlas J Tincherry
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Unknown
15. Birthplace: North Carolina

16. Informant: Mrs. Mary C. Tincherry
Address: 4203 Eastern Ave Mt Rainier

17. removal — Date thereof: Jan 10, 1947.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Lee Funeral Home
Location: 4th & Mass Ave N.E Washington D.C.

16. Funeral director: F Geschè sons
Address: Hyattsville Md.

19. Jan 10 1947 Mrs. Jean Devere
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1947, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute methyl Salicylate poisoning	
Due to Drinking about 2 ounces of Methyl Salicylate	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 1-9-47
Where did injury occur? Mt Rainier (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Wood Methyl Salicylate Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other
Address: Forestville Md Date signed 1-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1-25

2-2450 —— 1-10

Evidence for the chan e of age is shown on G 108 2/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 1a

00835

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Fort Pleasant Rd (If outside city or town limits, write RURAL and give nearest town)
Street No. 527-68 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles H. Welsh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret Welsh
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 21. 1869

8. AGE: Years	Months	Days	If less than one day
77	7 8/1		hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Retired
FATHER 12. Name: Charles Welsh
FATHER 13. Birthplace: Pa
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: Pa
16. Informant: Charles Welsh
Address: 4235 Rusk st Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D.C.
18. Funeral director: F Gracha sons
Address: Hyattsville md
19. 1/7/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5th 1947 at 11:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3rd 1947, to Jan. 5th 1947 and that I last saw him alive on Jan. 4th 1947

Immediate cause of death	DURATION
Cardiac Renal disease Hypertension	?
Due to: Arteriosclerosis Prostate ?	
Due to: Uremia	Overday
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: F. Apgar M.D. or other
Address: Fort Pleasant Md Date signed: Jan. 5, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-3 J-

Welsh
Evidence for the change of year of birth is shown on B 108 2/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00836

Reg. Dist. No. 2457

1. PLACE OF DEATH:
County Prince George's
City or town 670 S Queens Chapel Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since Jan. 3, 1947.
Hospital, institution, or street address where death occurred: 670 S Queens Chapel Rd Hyattsville, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 670 S Queens Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maggie M. Welsh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Walsh

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 8. 1878

8. AGE:

Years	Months	Days	If less than one day
68			____ hrs. ____ min.

9. Birthplace Penna (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name ? Crawford
13. Birthplace Penna

MOTHER
14. Maiden name Unknown
15. Birthplace Penna?

16. Informant Joseph Walsh
Address University Park Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1, 1947. (month) (day) (year)
Cemetery or crematory Lot Lincoln Colman Crawford Md
Location Washington
18. Funeral director F Gabrels Sons
Address Hyattsville Md.
19. Feb 1 1947 (Date rec'd by registrar) Mrs. Jno. Sevens Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1947, at ____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1946, to Jan. 30, 1947
and that I last saw her alive on Jan. 24, 1947

Immediate cause of death	DURATION
Card. Vascular renal disease	One yr
Due to Congestive heart failure	-
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. Apgar, M. D. or other
Address Beat Pleasant Md. Date signed Jan. 30, 1947
Clock Lot 195.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. James L. Boyd,
Medical Examiner
Notified Jan. 30, 1947.

1-25

2-2452-1-10

Evidence for the change of
age is shown on
G 108 2/6/47

00837

93d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George County
City or town: Riverdale, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hrs.
Hospital, institution, or street address where death occurred: Leland Memorial Hosp. Riverdale, Md.
How long in hospital or institution? 13 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Wash. D.C. County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 1338 4th St S.W. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Mrs. Lillian Williams
3. (b) Social Security Number

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Joseph W. Williams
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 7, ~~1861~~ 1861
8. AGE: Years 85 ~~[illegible]~~ Months 9 Days 13 If less than one day ... hrs. ... min.
9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —
FATHER 12. Name: Francis Guest
13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Rachel Withmore
15. Birthplace: Washington, D.C.
16. Informant: Anna W. Priddy
Address: 510 Peabody St N.W. Wash. D.C.
17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Jan 23-47 (month) (day) (year)
Cemetery or crematory: Congressional Cem.
Location: Washington D.C.
18. Funeral director: W W Chambers Co
Address: 1400 Chapin St. N.W.
19. Jan 20 1947 James Severy (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 1947, at 2:04 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 20 1947
and that I last saw her alive on Jan 19 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: arteriosclerosis, Hypertensive cardiac disease	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Henry J. Hadley MD (M.D. or other)
Address: 1252 ... Date signed: Jan 20 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

00838

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: PRINCE GEORGE
City or town: BOULEVARD HGTS MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: PRINCE GEORGE
City or town: BOULEVARD HGTS MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4804 BYERS ST
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROBERT. WOLFE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE.	WHITE.	WIDOWED.

6.(b) Name of husband or wife: CATHERINE. E.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH. 12. 1876

8. AGE:

Years	Months	Days	If less than one day
70	11	13	hrs. min.

9. Birthplace: BROOKLYN. N.Y. (Town, county, and state)
10. Usual occupation: RETIRED.
11. Industry or business
FATHER 12. Name: UNKNOWN
13. Birthplace: UNKNOWN
MOTHER 14. Maiden name: LOUISA. F. BOWMAN.
15. Birthplace: UNKNOWN
16. Informant: HAZEL. D. KELLER.
Address: 4709 3rd Pl. N.W.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1-27-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg, Md.
18. Funeral director: S.W. Chambers Co.
Address: 517 11th St. S.E.
19. 1/25 1947 (Date rec'd by registrar) Thos J. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 25 1947 at 2.20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1 1947, to Jan. 25 1947 and that I last saw h. alive on Jan. 25 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hrs
Due to: General Arteriosclerosis	Unknown
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury: — Injured at work?

23. SIGNATURE: Joel C. Van Gaasbeek M. D. or other
Address: Washington 19DC Date signed: Jan 25 1947

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